

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031611

FILED VS AUG 16 1960

ENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 102

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Pike				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pike			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Louisiana		Length of stay in lb		c. CITY OR TOWN Louisiana		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 415 So. 5th Str		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle M. Last Roberts				4. DATE OF DEATH Month Aug. Day 9 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-9-85	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) New Harmony, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Geo. W. Thurman		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Jerry G. Roberts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mason Ogden Bowling Green, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: Coccyx of sigmoid bowel with obstruction DUE TO (b) metastases DUE TO (c) metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 wks. 10 months	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 11/23/59 to 8/9/60 and last saw her alive on 8/9/60		Death occurred at 10:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Thos H. Lavelle (Degree or title) M.D.		22b. ADDRESS 122 South 3rd St., Louisiana, Mo.		22c. DATE SIGNED 8/10/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-11-60		23c. NAME OF CEMETERY OR CREMATORY New Harmony Cemetary		23d. LOCATION (City, town, or county) (State) New Harmony, Missouri.	
24. FUNERAL DIRECTOR William B. Water, Vandalia Mo		ADDRESS		25. DATE RECD. BY LOCAL REG. Aug 11-1960		26. REGISTRAR'S SIGNATURE Bernice Collier	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

REC-28 1967

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William B Waters

Licensed Embalmer No. 4169
P. O. Address Sandalia, Pa.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.